



Appointments: 877-411-DOZE
Office: 703-348-7857
Fax: 703-783-8770
www.SleepHeart.com

RECORDS REQUEST FORM

Please complete and fax (703-783-8770) or mail this form to SleepHeart at 1850 Town Center Parkway, Suite 303, Reston, VA 20190 and we will send the requested documents within 15 days (typical turn around is 2 business days).

PATIENT INFORMATION

Name Date of Birth Email
Phone: Cell Home Work

Documents Requested

RECIPIENTS:

Email Address (by specifying email addresses, you acknowledge and understand that email is not secure and agree to hold harmless SleepHeart and its agents, owners, and physicians harmless for any loss of confidentiality, there is no charge for having documents emailed).

Mailing Address (please include a check for \$10 for each address within the US).

Referring Physician Name and fax number:

I hereby authorize the above release of medical records.

Printed Name Signature Date